LAOS TRIP REPORT

JULY 23, 2004

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Tables

Annexes

ACRONYMS

ANC	Antenatal Care
BF	Breastfeeding
EmOC	Emergency Obstetric Care
FP	Family Planning
HC	Health Center
IFA	Iron Folate Acid
LBW	Low Birth Weight
MNH	Maternal and Newborn Health
MMR	Maternal Mortality Ratio
MM	Model Mother
NMR	Neonatal Mortality Rate
PH	Provincial Hospital
PPH	Post-Partum Hemorrhage
PSI	Population Services International
QoC	Quality of Care
SB	Stillbirth
STI	Sexually Transmitted Infections
TBA	Traditional Birth Attendant
TOT	Training of Trainers
TT	Tetanus Toxoid
VHW	Village Health Worker
WV	Word Vision
USAID	United States Agency for International Development

I. Purpose of Visit

The purpose of the visit was to work with World Vision Laos (WVL) and Population Services International (PSI) to conduct a training of trainers (TOT) workshop for selected staff from the province, and two districts (Atsaphone and Atsaphangthong). Activities to be accomplished, in collaboration with WVL and PSI during the visit are outlined below.

- To prepare and conduct the a training of trainers, to develop at least 5 master trainers in antenatal care, labor and delivery, family planning, optimal birth spacing, post-partum care and newborn care.
- To support the master trainers in conducting their first district level training.
- To assess the feasibility of the transport model for accessing emergency obstetric care (EmOC) services.
- To review the draft baseline survey results and provide comments.
- To brief/debrief the U.S. Embassy/Laos about the SMD project.

II. Activities and Findings

A. Meetings

The consultant met with the with PSI (Dr. Vanmaly Savannary, PSI Technical Director) and WVL staff (Eyob, Dr. Aeudom, Helen Davies) in Vietanne to review the approach fpr both the TOT and district level training, discuss the training agenda, review logistics needs and translation of materials.

In collaboration with WVL and PSI, met with Dr, Panom, to brief him on the training and gain insight on areas he would like emphasized. He was very supportive of the meeting and said that the province representative would open the meeting

Ms. Ross provided a debriefing to Mr. Scot Rolston at the US Embassy in Laos including an update on the field visit, transportation issues and the training.

B. Summary of Baseline

As expected, the communities surveyed are quite poor. Half of the women had never been to school and 53% cannot read Lao. Thirty two percent of women had given birth by the time they were 18 yrs old. Almost half (45%) of women had a live child less than 1 yr and 27% of women had 2 children between the ages of 2-5 yrs.

Access to health services is low. While 31% of households owned hand tractors, fuel is expensive. The study found that 40% of women **had never** been to a Health Center (HC). Most women (71%) had **not** received antenatal care (ANC) services during their last pregnancy.

Of those who sought ANC services, most saw midwife, TBA or VHW (all 28%). Most women who received ANC services at a health facility went to the provincial hospital (PH) (28%) or HC (27%) followed by 5% who went to the district hospital (DH). *(note: these figures may vary greatly between the two districts; disaggregated district data was not available at the time of my visit).*

Of those who came for ANC services, 11% received 4 visits; 38% received 3 visits; 17% received 2 visits and 20% received 1 visit. However, most sought services in the 6 month (8%) while 11% only received their first visit in the third trimester. Twenty-three (23%) percent of ANC women received IFA and only 1% received treatment for parasites during their last pregnancy. In addition, 35% of ANC women had never received any TT immunizations, 13% received 1 TT dose while 20% received TT2.

Knowledge of danger signs, during pregnancy, labor and delivery and the post-partum period was exceedingly low. Knoweldge of danger signs during pregnancy ranged from 0.3% knowing that high blood pressure was a problem to 1% understanding that swelling was a problem. Less than half (43%) of women said they had a birth plan and 58% had cash on hand. *(note: I think this will vary greatly between the districts).* In additional about half said they had access to cash- however it was not clear if ***"the access"*** was through highly priced loans which results in greater poverty.

As stated previously, during labor and delivery knowledge of danger signs was low: 1) 2% of women knew too much bleeding was a problem; 2) about 1% knew high blood pressure and swelling were problems; and 3) less than 1% knew that if the baby was in the wrong position or if a woman had convulsions there was a problem.

Most women (85%) delivered their last baby at home; 9% delivered at the DH. When asked for their preferred delivery site for their next child, almost half (46%) wanted to deliver at home, 33% at the DH and 15% did not know. Most women (75%) used bamboo to cut the cord and 18% used scissors. Only 11% of women said that the materials were boiled. Many women (72%) said they used a clean delivery kit. I think that they have not understood this question because the answers are not consistent with the other answers on this topic.

About 11% of women had complications during their last pregnancy. Pre-eclampsia/ eclampsia were the most common known complications (3.8% high blood pressure and swelling) and another 0.8% had convulsions. About 6% had difficulties but were not sure what they were. Of those that had problems, most (43%) went to the DH followed by 36% who stayed home; 5% went to the TBA and another 5% went to the VHW.

About a third (39%) of women abstained from sex for 1 month after delivery; only 2.8% abstained for 4 months. Twenty percent of women knew that they could have space between their children by using contraceptives. About half (48%) of the woman asked did not know any benefits of birth spacing for the mother or the newborn. Of the women who knew of any benefits for the mother or newborn, a third wanted to have 3 yrs between pregnancies; only 11% wanted 24 months

Most women (79%) had **never** used a FP method. Of the 10% who **had ever,** at some point in their life, used a FP method, most used Depo (23%), the pill (22%), the IUD (1.7%), diaphragm (1.4%) and female sterilization (1.4%). Currently the contraceptive prevalence rate is 11% with the following method mix: pills (59%), IUDs (3%), Depo (44%), condoms (0.3%). Most women stopped using a FP method because they wanted another child (32%), had side effects (24%), heard rumors (1%), too expensive (0.3%). Women received FP supplies from the DH (51%), pharmacies (29%) and HC (17%).

Twenty percent (20%) of women with more than one child wanted to wait between pregnancies spacing); another 20% of women with more than one child wanted no more children (limiting). Thus 40% of women would like to use a FP method. This means that the unmet need for FP services is 29% **(women who would like to use FP 40% - current CPR is 11%=29% unmet need).** About half of this need is for spacing methods (pills, condoms, Depo, IUD) and half is for limiting methods (VSC). When asked about intended future FP use; 11% intend to use the pill, 0.3% the IUD, 28% Depo, 1.4% condoms and 2.5% female sterilization.

Almost half (42%) of babies were registered but only 12% of newborns were weighed. Most babies (73%) were bathed in the first hr; only 8.5% were bathed after the first 24hrs. Most were breastfed but only a third began breastfeeding within the first hour; close to half (42%) were breastfed sometime during the first day. Most women (84%) gave the baby something other than breast milk before 4 months. Women were most likely to give chewed stick rice (82%).

As with the mother, knowledge of newborn danger signs was very low. As stated previously, bamboo was the most commonly used instrument to cut the cord, followed by kitchen knife. Most women put something on the cord, including alcohol or ash. About a third (30%) knew fever was a problem followed by difficulty breastfeeding (6%), difficulty breathing (1.7%) and redness/infection of the cord (0.3%). No one mentioned tetanus, jaundice, low birth weight or hypothermia as problems. If there was a problem, most Families (60%) took the newborn to the DH, followed by HC (25%), VHW (4%) and PH (0.8%). Most women (76%) who had LBW babies did not receive any messages on how to care for a LBW baby.

C. Provincial Hospital Visit

The maternity and obstetrics ward was moved to the Provincial Hospital premises in March 2004. The facility was a large cement building with 10 labor beds, 10 beds for post-partum and 10 ob/gyn beds. There was one room with two delivery beds, separated by a curtain and 1 Operating room adjacent to the labor beds. At the time of our visit there was no one in labor or delivery and only one post-partum mother. The staff told us that they see about 50 deliveries a month and 5 C-Sections. They said women only stay 1-2 hrs after delivery. They were using paratograph to monitor women in labor, but it was still very new to them. They had only been trained in Oct 2003.

D. Field Visit

1. Phontoum Village

We visited Phontoum, an ethnic Lao village, which is15 kms from the DH and 4kms from the HC. On the day we went to the village, the road to get to the village was flooded in 6 places; we were only able to get through because we had a four-wheel drive vehicle. The hand tractors were stuck in many of these areas.

Phontoum had a male VHW, who had been trained as a nurse, and a female TBA. The VHW's wife had been pregnant 7 times and had 5 children that were live births. She only has 2 currently living children; the other 3 died before their fifth birthday from diarrhea. She had never gone for any ANC services; she had never taken iron or received TT. She is currently using Depo but still wanted more children.

The VHW was a retired nurse, so he told us that he had treated women who had retained placenta. He said that if the woman or newborn pro-blems they would go to the hospital, but he also said people in the villages were very poor and most could not afford to go to the DH.

We were told that transport was a major cost—100,000Kip ($10) one-way to the hospital —and barrier to accessing health services. The people we spoke with estimated that 85% of the people in the village were too poor to pay these costs. They said that there were people in the village who had hand tractor and they could easily access them. They said that if it was an emergency the hand tractor owner would take the woman to the hospital and the family could pay later. However, many families had to borrow money from family/community members who charge 10% interest a month. They also said that the cost of services was a major problem. It costs about 60,000kip ($6) for a normal delivery and more for any com-plications. (Note: according to the baseline the annual salary of $10). Thus, transport itself does not seem to be the problem, the main issues are both the cost of transport and services as well as access to cash.

We were told that even though the HC was closer (only 4kms) they pre-ferred to go to the DH because they had more confidence in them. If women received any ANC care it was from the TBA. The TBA told us that she palpated the women's abdomen to check for the baby's position and encouraged women to go to hospital to receive iron. Although there is a quarterly (immunization) mobile clinic most women had not received any TT. It was unclear if the mobile clinic came regularly. The women we spoke with thought that pregnancy is normal so there is no reason for ANC. They said that if a woman has problems she would go to the hos-pital, but the only danger signs mentioned were bleeding and convulsions.

The TBAs said that when she is called she goes to the house. If she has time she will boil the clamp, scissors and string for 30 min. But if there is no time she just uses them as they are; she did not say that she washed her hands but after we asked she said yes. She said that puts ash on the cord to protect the baby- the other women also said that they do the same if they deliver by themselves or with family members. They either use a kitchen knife or bamboo to cut the cord.

We met two model mothers (MMs); the other three were in the field trans-planting rice. The first woman had two children- one that was 4 yrs and another 5months. The TBA helped her with both deliveries. She received ANC from TBA, but has never taken iron or received TT. She said that she didn't have the money to go for ANC at the hospital. She wants a few more children but she is not using FP because it is too expensive. The other MM had 3 children—4yrs, 3yrs, 1.5yrs. She had received ANC for her first child from the TBA but not for the other two children. She had received 1 TT shot from a mobile clinic, but had never taken any iron. The TBA had helped her with her first delivery but she saw no reason to call her for the subsequent births; her husband helped her deliver. She wanted at least 2 more children. She agreed that transport costs were very high as well as FP.

2. Atsaphone Health Center

After visiting the village, we went to the HC that was 4kms away. Most people in the village said they had never been to the HC. The facility was big cement structure and better maintained than the Atsaphone (wooden structured) hospital. We met with the female nurse who was posted there. She said the HC was responsible for 13 villages. When we asked why women didn't come to the HC for ANC she said they preferred to go o the TBA. When we told her that the people in Phontoum had never received any iron or TT she told us that she visits (by motorbike) all the villages. She said that she takes iron, BP cuff, scale and Vitamin A when she goes. However, the village never indicated that someone from the HC came to the village. The nurse did not seem to have any kind of schedule to visit villages; she said that she goes to some villages once a month others once a quarter.

We asked about her relationship with the TBAs. She said that she doesn't have any meetings with them and they do not provide any information to the HC or the district. When asked if the HC meets with the district staff she said there are no meetings. She said that they have to do a monthly report and they send it with someone going to the district but there is no meeting.

3. Atsaphanthong Health Center

Due to limited time we only had time to visit the HC. We met with the male medical assistance posted in the HC, we had met him on the previous visit. He is still having challenges about getting women to come for ANC, but women are coming for post-partum care and family planning, as well as for their baby's immunizations. We asked him about FP methods appropriate for post-partum women. He told us they could use condoms, Depo-Provera and combined oral pills. We questioned whether breast-feeding women could use combined pills; he said yes- we explained why this was incorrect.

He told us that he meets with the TBAs once a month. They have a pic-torial form that the province designed (which is quite good). The TBAs bring the forms to the HC on the 10th of every month. While they are there he provides refresher training and answers questions. He said that he summarizes this data and takes it to the monthly meet at the district on the 14th .of every month.

III. Training of Trainers (Master Level Training)

The meeting was opened by Mr. Eyob, World Vision Team Leader and the Provincial Training Officer.

Most of the staff selected for the training was providing direct MCH client services. A few were more removed. For example, in Athsaphone one of the participants was from the district health education office, so we invited two people who provided MCH services in the district hospital as well. The two provincial representatives were TBA trainers. While the training will improve their abilities for training TBAs, they do not work directly with the districts. These individuals had less clinical knowledge than their peers. Also, since Atsaphanthong is an inter-regional hospital, the staff was more knowledgeable than some of the Athsaphone staff.

The participants were very shy and it was difficult to get them to ask questions or start discussion in the beginning. Some participants never spoke unless I called on them directly. Most were very reluctant to participants in role plays but they became more comfortable as the training progressed. The list of participants, agenda and lesson plans are in Annex A

In general the knowledge level of the participants were very low. They did not know the major causes of maternal deaths and they were not confident in this until the second day. They also had little knowledge about maternal danger signs; they were most familiar were bleeding, swelling in ankles and convulsions; they did not spontaneously state obstructed/prolonged labor or infection.

In terms of Antenatal Care:

- They knew that they should provide IFA and TT to women, but there was confusion about the appropriate IFA dose.
- They were not screening or treating pregnant women for any infections (e.g., malaria, parasites) and did not know the appropriate treatment.
- They had fairly good knowledge about measuring the uterine height to assess gestation and to check position of the fetus.
- They did not seem to understand the importance of taking vital signs and what they indicate. People often forgot to say they should take the woman's BP or listen to the baby's heartbeat when asked or during role plays.

In terms of Labor (first and second stage)

- They were not clear on what should be monitored—they forgot vital signs, cervical dilation and temp. They were also not clear on how often they should monitor the woman during labor and what indicated a problem.
- They did not have a good understanding of dangers signs and appropriate treatment; few had ever seen complications.
- Since the provincial hospital staff had only been trained on partograph in Oct 2003 and the district staff had never seen a partographs, the general idea was introduced and the way it could be used. But since they were not using it in their facilities they were not expected to complete during the training

In terms of Delivery (active third stage)

- They had a fairly good understanding of the delivery process (when to have the woman push, rotating the babies shoulder, cord traction).
- Staff in Atspahone does not give any oxytoic drug after the baby is born while in Atsaphonthong they give erogmetrine.
- The nurses were not allowed to remove retained placental pieces, the doctor had to be called.
- Even though many of them knew that bleeding was a problem, only two providers had ever experienced this type of case. They were unsure how estimate blood loss and they could say too much bleeding but they could not identify this. No one ever had a case of a woman with convulsions.

In terms of Post-partum Care

- Many knew that most women die in the post-partum period, but they did not understand the timing (when women die from PPH or infections). They thought one visit at 6wks was enough.
- They said they provide counseling on: 1) nutrition (no foods are prohibited), 2) providing breastfeeding on demand (do not give anything else) and 3) not lie on the fire. They give the woman 100 IFA tablets and one dose of Vit A (200,000IUs).
- They had fairly good knowledge about assessing uterine status, they were less clear on what a woman should expect in terms of normal discharge and bleeding after delivery.

In terms of Family Planning/OBS and Post-Partum FP

- They had fairly good knowledge most of the methods, they knew least about sterilization, progestin only pill and LAM.
- Most staff thought there should be space between child to give the mother a chance to be healthy. The MOH policy is 2 years, so the message was that 2 yrs is the minimum amount but if they waited 3 yrs it would be even better for both the mother and newborn.
- They were not aware that IUDs could be inserted right after delivery (first 48hrs).
- They were fairly familiar with the GATHER approach for counseling.

In terms of Newborn care

- They knew that they should suction the baby's nose and mouth but were unclear what to do if the baby didn't breathe.
- The understood that you should dry the baby and give them to their mother to keep the baby warm, however they said they give the baby a bath in the first hr.
- They had fairly good understanding about cutting and tying the cord with something clean; they said they used to put alcohol on the cord. Some said they still do while others said they put nothing.
- They said BF should begin as soon as possible, the mother should only give BF, no other fluids/food should be given and it should be done on demand.
- They knew very little about managing low birth weigh babies.
- For danger signs they knew fever and convulsions. None of them has ever seen a baby with tetanus and they were confused about normal and abnormal jaundice. They did not know any of the treatments for these conditions.

In terms of Training Methods
Most of the staff had never had a role as a trainer. We covered: 1) basic concepts of adult learning theory, 2) how to develop lesson plans and plan activities (in addition to Lectures) and 3) the use of handouts. Groups of 2-3 people were assigned Lesson Plans 1-9 for the District Training. On the last day of the training, each group prepared the key points to be discussed in the session and how they would undertake the training. This was presented to the entire group who gave feedback. Based on the comments they finalized the lesson plans and conducted the session the following week.

Evaluation of Training
The participants thought that all the sessions were useful and they wanted to know about all the topics. They said they wanted the training to be longer, but when asked it was unclear which specific topics they would have wanted to be longer.

IV. Master Level Training of District Level Staff

There were five providers selected from each district for a total of 10 participants. There were 3 trainees who did not provide direct client services. There was one person from the relevant health centers from each district. As previously described, the Atsaphanthong staff had more knowledge and were more outspoken than the Athsaphone staff. A list of participants and the agenda is included in Annex B.

The participants were very shy and it was difficult to get them to ask questions or start discussion in the beginning. In general the knowledge level of the participants was very low, even lower than the trainers as described above, thus it is not repeated here. Most of them had never been in a workshop like this before.

As stated previously, the small groups of trainers had been assigned each of the lesson plans. The WV staff functioned as the overall facilitator and moderator. Table 1 provides a summary of the trainers strengths and weaknesses.

Table 1: Performance of Trainers

Strengths	Weaknesses
Good Eye Contact	Low energy-soft spoken
Foster Discussions	Need to improve on getting shy people to speak
Fairly well prepared; most used handouts well.	Managing off-topic discussions
Provide clear instructions for group activities	Improve understanding of the technical content
Use of role play	Developing objectives and lesson plans

Evaluation of the Training
In terms of the content, the participants thought that all the sessions were useful and they wanted to know about all the topics. They said they wanted the training to be longer and/or to have other trainings like this in the future. The participant also commented on the trainers performance which is reflected in Table 1.

V. Recommendations

Table 2 provides a summary of the key recommendations and/or next steps for the SMD project.

Table 2: Summary of Recommendations

Issue	Recommendations	Comments
Vitamin A	Recommended dose is 1 table 200,000 IUs within the first 4 weeks to post-partum woman	MOH guidelines it says 2 doses which incorrect
Birth Planning Cards	Few minor changes, otherwise it is ready for printing	
IFA	MOH recommends 100 tablets PP as well ANC	
Malaria in pregnant women	Cholorquine - this is recommended since it is still effective in Lao. If a woman doesn't respond then give SP.	MOH guidelines uses African Protocol with SP
Neonatal tetanus	WV needs to clarify tx protocol with MOH	Confusion over MOH Guidelines
Newborn Bath	Encourage families not to bath the baby in the first 12 hours. If LBW baby wait for 24 hrs	Do not remove vernix, it protects the baby.
Oxytocin Drugs in Third Stage	WV needs to discuss with Athsaphone staff	
Pilot transport system	Work with comm to develop a structure to manage comm loan program that people can access for transport/services when there is a complication	important to have comm contributions
Relationships between TBAs and HC staff	Facilitate a relationship between TBAs, HCs, district staff. This happens regularly in Atsaphanthong, it would be good to have similar approach in Athsaphone.	
Relationships between districts	Since Atsaphanthong is the inter-regional hospital, it might be useful to have the people visit each other or find ways to create stronger relationships/teamwork between the 2 districts.	
Reinforce Technical Topics	Areas to reinforce with trainers include : monitoring women during labor, tx of ANC infections, LBW, newborn danger signs, POPs, LAM	Still seem weak in these areas.
Screens on the window	WV should negotiate with MOH to ensure that there are screens on the windows of the new hospital in Athsaphone	
Support for outreach	WV should help HC staff should make a regular schedule for community outreach- they should be aware of the date, place and time so they can mobilize people	
Support for refresher training	WV should support the trainers during refresher training at monthly/quarterly meetings	

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ANNEX A:
Master Trainers and District Level Trainees

Master Training Participants

Name	Title	Location
Mrs. Souphalak	Medical Assistant	Atsaphanthong Hospital
Mrs. Phonekeo	Medical Assistant	Atsaphanthong Hospital
Mrs. Chamsy	Medical Assistant	Athsaphone Hospital
Mrs. Khomseng	Nurse	Athsaphone Hospital
Mr. Sichan	Medical Assistant	Athsaphone District Health Office
Mrs. Kotamy	Medical Assistant	Provincial TBA Trainer
Mrs. Keanchamh	Medical Assistant	Provincial TBA Trainer
Ms. Vilaythong	Doctor	WVL
Mr. Aeudom	Doctor	WVL

District Training Participants

Name	Title	Location
Mrs. Siprasearth	Medical Assistant	Atsaphanthong Hospital
Mrs. Seangehanh	Medical Assistant	Atsaphanthong Hospital
Mr. Boumlearth	Nurse	Atsaphanthong Hospital
Ms. Siymuang	Nurse	Atsaphanthong Hospital
Mr. Vilaysome	Nurse	Athsaphanthong Dispensary/health center
Mr. Khamkearth	Nurse	Athsaphone Hospital
Mr. Chamthavong	Nurse	Athsaphone Hospital
Mrs. Somphone	Nurse	Athsaphone Hospital
Mrs. Phetsamome	Medical Assistant	Athsaphone Health Center
Mrs. Kolakanh	Nurse	Athsaphone Hospital

ANNEX B:
Agenda and Lesson Plans

Time	JULY 7	July 8	July 9
9:00-9:30	**Opening** Provincial Trainer	Recap	Recap
9:30-10:00	**Ice breaker/Expectations/** SMD Objectives: Aeudom	Post-partum Care both at the facility and the home, and infection prevention, room readiness	Continue training Methods
10:00-10:30	Overview of maternal mortality and morbidity		
10:30-10:45	**Break**	**Break**	**Break**
10:45-11:30	Antenatal Care; normal and danger signs, both at the facility and the home	Post-partum FP/OBS (PSI)	Prep for first assigned lesson plan
11:30-12:00	Role Play ANC counseling sessions		Practice, with feedback
12-1:30	**Lunch**	**Lunch**	**Lunch**
1:30-2:00	Labor Role Play	Newborn care both at the facility and the home	Prep for second assigned lesson plans and practice
2:00-3:00	Normal delivery-counseling, exam, room readiness/ infection prevention		
3:00-3:15	**Break**	**Break**	
3:15-4:00	Delivery complications, danger signs and appropriate treatment	Care of LBW	
4:00-4:30		Training Methods- principles of adult learning theory, brainstorming, reflective, listening/hearing	Prep for second level training (agenda, logistics)
4:30-5		Assign training sessions to groups	

Lesson Plan 1: Expectations and Objectives

Session Objectives

1. To review the agenda and provide an overview of the workshop.
2. To clarify participant's expectations of the workshop.
3. To review the objectives of the SMD project.

Workshop Objectives

Time: 30 minutes

Resources:

1. Agenda
2. Flipchart/Markers or Index Cards

Lesson Plan 2: Understanding Maternal Mortality

Session Objectives

1. To review international data on maternal mortality and morbidity to understand the key issues that women face.
2. To understand the importance of how quality ANC, labor and delivery care and post-partum care contributes to improved maternal and newborn survival.
3. To understand the delays that both women and newborns face in accessing quality services

Time: 30 minutes

Resources:

Power Point Presentation

1. Story from Manual

Lesson Plan 3: Understanding Antenatal Care

Session Objectives

1. To review the rationale of the key ANC interventions, including
   - counseling including a birth plan
   - physical exams/monitoring pregnancy progress
   - providing iron and folic acid (IFA) supplementation during pregnancy
   - providing tetanus immunization (TT1 and TT2)
   - assessing for infections such as parasites, malaria or urinary tract infections; treatment if needed
2. To discuss strategies to encourage women to seek ANC on a regular basis, beginning at least in the fourth month of pregnancy.
3. To understand cultural practices that: 1) benefit the pregnant mother/baby and 2) those that are not beneficial.
4. To discuss key messages to be given to TBAs, family members and women about the danger signs that would indicate that they would need to come to the health facility and at a minimum the importance of a clean delivery.

Time: 60 minutes

Resources:

1. Ministry of Health Guidelines: Antenatal Care
2. Ministry of Health Guidelines: Information on MCH Services
3. Handout 1: Summary of ANC Interventions
4. Birth Planning Card

Lesson Plan 4: Understanding Labor

Session Objectives

1. To review signs of labor (e.g. cervical dilation, effacement, fetal heartbeat) and counseling women and their families on what to expect during the labor process.
2. To understand the key danger signs (e.g., bleeding, increase in blood pressure, severe headache, convulsions, fever, no progress of the contractions/dilation, fetal heart rate less than 100) that should be monitored during labor and to know appropriate actions should these complications arise.
3. To understand cultural practices that may influence the labor process (e.g., when does labor begin, how long is labor suppose to last).
4. To identify why women are not delivering in health facilities and to discuss strategies to encourage women to: 1) deliver in an institution; 2) with a trained TBA; and/or 3) with family members.
5. To discuss key messages to be given to TBAs, family members and women about the danger signs that would indicate that they would need to come to the health facility and at a minimum the importance of a clean delivery.

Time: 60 minutes

Resources:

1. Ministry of Health Guidelines on Labor and Delivery
2. Birth Planning Cards

Lesson Plan 5: Normal Delivery (Third Stage Labor)

Session Objectives

1. To review the delivery process, appropriate medication, and management of normal births.
2. To review appropriate management of third stage (e.g., oxytocin after delivery, delivery of the placenta, assess the placenta is intact).
3. Assess uterine height, contractions, consistency (e.g., hard, soft), blood flow.
5. To understand the importance of infection prevention practices both at home and in health facilities.

Time: 60 minutes

Resources:

1. Ministry of Health Guidelines on Labor and Delivery

Lesson Plan 6: Delivery Complications

Session Objectives

1. To review what materials need to be ready for a forceps/vacuum delivery or a C-section (both room readiness and infection prevention practices).
2. To understand the causes of pre-eclampsia/eclampsia and appropriate actions/treatments.
3. To understand the causes of obstructed labor and appropriate actions/treatments.
4. To understand the causes of bleeding/hemorrhage and appropriate actions/treatments.
5. To understand the causes of infection/sepsis and appropriate actions/treatments.

Time: 60 minutes

Resources:

1. Ministry of Health Guidelines on Labor and Delivery

Lesson Plan 7: Post-Partum Care (Maternal)

Session Objectives

1. To understand the important of post-partum care for the mother (e.g., most deaths occur during the PP period)
2. To know the appropriate skills and information to provide the post-partum women during:
   - ➔ First 6-12 hours
   - ➔ 12-24hrs
   - ➔ 5-7 days
   - ➔ 4-6 weeks

Time: 60 minutes

Resources:

1. Ministry of Health Guidelines on Post-Partum Care
2. Hand Out 3: Post-Partum Care

Lesson Plan 8: Post-Partum Family Planning

Session Objectives

1. To understand the importance and benefits of beginning birth spacing immediately after delivery.
2. To understand how breastfeeding impacts on the return to fertility and how long a couple is protected while exclusively breastfeeding.
3. To understand which FP options are appropriate for breastfeeding and non-breastfeeding women.
4. To know the key information to counsel women/couples on regarding post-partum family planning methods.

Time: 60 minutes

Resources:

1. Ministry of Health Guidelines on Post-Partum Care
2. Handout 4: Post-Partum Family Planning

Lesson Plan 9:
Understanding Perinatal and Neonatal Mortality

Session Objectives:

1. To understand reasons why newborn health is important for child survival.

2. To understand why the mother and the baby will benefit from an integrated focus.

3. To learn about the magnitude of fetal/neonatal mortality as well as the when and where those deaths occur.

Time: (60 Minutes)

Resources:

1. Power Point Presentation: Overview of the Global Issues with Perinatal and Neonatal Mortality.
2. Hand Out: Distribution of Neonatal deaths
3. Hand Out: Essential, Extra and Emergency Newborn Care

Lesson Plan 10:Training Methods

Session Objectives

1. To review key principles of adult learning theory.
2. To discuss a variety of participatory approaches that will facilitate adult learning theory.
3. To review the role of the facilitator to enhance participant's skills.
4. To understand the best approaches to manage group work.
5. To practice these techniques with the other trainers.

Time: 60 minutes

1. **Resources:**
2. Handout 7: Adult Learning Theory
3. Handout 8: Role of the Facilitator
4. Handout 9: Managing Small Groups